

# Siena College Health Service

515 Loudon Road  
Loudonville, NY 12211  
(518) 783-2554  
Fax (518) 783-2961

## Authorization for Release of Medical Records

To: Siena College Health Service

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

1. I hereby authorize \_\_\_\_\_

to disclose information from the medical record of:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

and to be sent to Siena College Health Service for the purpose of continued medical care.

Please fax to the above Fax #. Please give an approximate date of treatment and where treatment took place: \_\_\_\_\_

Please (X)      ( ) The complete medical record  
                  ( ) Other (specify) \_\_\_\_\_

I understand that information released pursuant to this authorization is governed by State and Federal confidentiality laws which prohibit re-disclosure to any recipient other than the one designated above without my written authorization. The facility, its employees, officers, and practitioners are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Parent, Guardian or  
Legal Representative

\_\_\_\_\_  
Print name of above signature